

NO STAPLES IN  
BAR CODE AREA

Dept of Labor & Industries  
Claims Section  
PO Box 44269  
Olympia WA 98504-4269

# STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

DO NOT  
WRITE IN  
SPACE



Instructions for completing form on  
the reverse side

Worker's name		Claim No.
Worker's home address (not PO Box)		Date of injury
Apt #		Social Security No. (for ID only)
City	State	ZIP + 4
Reimburse Injured Worker		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate Vocational Rehabilitation Counselors name and telephone number		REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form. <b>INJURED WORKER'S SIGNATURE:</b> <b>X</b>

## Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$      ¢	UNIT	TO DATE OF SERVICE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

Submission of this bill certifies the material furnished, service provided, expense incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid.

PROVIDER SIGNATURE:

Bill date:

**X**

Provider name	Provider number	Total Charge
Address		Phone Number
City	State	ZIP+4
Your Client's Account Number		
Federal tax ID number	<input type="checkbox"/> EIN <input type="checkbox"/> SSN	

L&I must receive this statement within 12 months of the date of service or claim allowance.

\* Place of Service (POS), Type of Service (TOS) and Procedure codes on back

**INSTRUCTIONS FOR COMPLETING RETRAINING AND JOB MODIFICATION SERVICES FORM**  
**(Retraining & Job mods only)**

**IMPORTANT:** Retraining mileage must be billed on a Travel Expense Voucher form for injured worker reimbursement. Please call the provider hotline at 1-800-848-0811 for the correct reimbursement form, F245-145-000.

**CLAIM NUMBER:** For the injured worker receiving services.

**STATE FUND INDUSTRIAL INSURANCE**

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits."

Send bills for Industrial Insurance claims to:

Department of Labor and Industries  
PO Box 44269  
Olympia WA 98504-4269

**CRIME VICTIMS**

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ or VK."

Send bills for Crime Victims claims to:

Department of Labor and Industries  
PO Box 44520  
Olympia WA 98504-4520

**SELF-INSURANCE**

Claim numbers are six digits beginning with an "S, T or W."

Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9."

Send bills to the employer or their service company.

**INJURED WORKER'S NAME:** Injured worker's full name, last name first.

**DATE OF INJURY:** This is important and must be included. One worker may have several claims, so it is vital the proper claim be identified and charged for services provided.

**HOME ADDRESS:** The injured worker's most current address (not PO Box).

**SOCIAL SECURITY NUMBER:** Record injured worker's social security number. It is helpful when the claim number is wrong and the worker's name is common.

**REIMBURSE INJURED WORKER:** Place an "X" in applicable box.

**WORKER'S SIGNATURE:** Worker's signature is required for claimant reimbursements. Forms not signed will be returned.

**VOCATIONAL REHAB COUNSELOR'S NAME AND TELEPHONE NUMBER**

**ITEMIZATION OF SERVICES AND CHARGES:** Receipts required for worker reimbursement.

**FROM DATE(s) OF SERVICE:** Record the date for each service provided (Note: for food only, a separate line is required for each receipt date).

**PLACE OF SERVICE (POS):** Put code 99 in this box.

**TYPE OF SERVICE (TOS):** Put type of service code "V" in this box.

**PROCEDURE CODE:** Please refer to the list of procedure codes below. Choose a code that best describes your service and enter it in the box.

**DESCRIBE SERVICES OR SUPPLIES FURNISHED:** Description of service(s) provided.

**CHARGES:** Charges for service provided. Original, itemized, dated & business stamped **RECEIPTS REQUIRED FOR WORKER REIMBURSEMENT.** For food receipts, items purchased must have a description.

**UNIT:** Number of days/units for the service billed on each line.

**TO DATE(s) OF SERVICE:** Record the date for each service provided (Note: for food only, a separate line is required for each receipt date).

**PROVIDER SIGNATURE:** Signature required for any provider billings. Forms not signed will be returned.

**PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** If any of this information changes, call 1-800-848-0811 immediately. *(Simply indicating a new address on the bill will not change L&I's record of address for the provider.)* For further information, find us at:

**[www.Lni.wa.gov/claimsinsurance/providerpav/billing/provider](http://www.Lni.wa.gov/claimsinsurance/providerpav/billing/provider)**

**PROVIDER NUMBER:** Identification number designated by the Department of Labor and Industries for the provider.

**TOTAL CHARGE:** Total of all charges for services provided.

**YOUR CLIENT'S ACCOUNT NUMBER:** The number used for providers to identify their client's account.

**CODES:**

**JOB MODIFICATION PROCEDURES CODES:**

0380R Job Modification  
0385R Pre-Job Accommodation Equipment

**RETRAINING PROCEDURE CODES:**

R0310 Tuition, Training Fees  
R0312 Supplies  
R0315 Equipment, Tools  
R0340 Books  
R0350 Other  
R0390 Child Care Services

**LODGING & RELOCATION:**

R0360 Board (Food) and Utilities  
R0370 Rent  
0375R One-Time Relocation Fee  
(for life-time of claim)

**RETRAINING TRANSPORTATION CODES:**

0302R Parking  
0303R Bridge and Ferry Tolls  
0304R Commercial Transportation